

# PETITION FOR CHANGE OF PHYSICIAN

Employee Name and Address:	Employer Name and Address:
Telephone Number:	
Social Security Number:	
Current Physician and Address:	Surety Name and Address (if known):
Requested Physician and Address:	Additional Information or Documentation Attached (Circle One):
	No                      Yes

Date of Injury/Disease:

General Information:

Medical Treatment to Date:

Reason for Change:

Hearing Date/Time Availability Next 30 Days:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

ORIGINAL TO EMPLOYER OR SURETY

Copy to Idaho Industrial Commission, 317 Main St., PO Box 83720,  
Boise, ID 83720-0041, or fax to 208-332-7558.

**CERTIFICATE OF SERVICE**

I hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, I caused to be served the Original Petition for Change of Physician upon either the following Employer or its Surety:

EMPLOYER'S NAME AND ADDRESS

SURETY'S NAME AND ADDRESS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OR

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

via:

☐ Personal Service of Process

☐ Personal Service of Process

via:

☐ Regular U. S. Mail

☐ Regular U.S. Mail

I also hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, I caused to be served a true and correct copy of the foregoing Petition for Change of Physician upon:

Idaho Industrial Commission  
317 Main Street  
Post Office Box 83720  
Boise, Idaho 83720-0041

via: ☐ Personal Service of Process

☐ Regular U. S. Mail

☐ Faxed to 208-332-7558

\_\_\_\_\_  
Signature